WEST MICHIGAN ACADEMY
OF ENVIRONMENTAL SCIENCE

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SCHOOL MEDICATION ADMINISTRATION AUTHORIZATION FORM

This order is valid only for school year 2018/2019 including the summer session.

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of medication.

- **Prescription medication must be in a container labeled by the pharmacist or prescriber.**
- **Non-prescription medication must be in the unopened, original container with the label intact.**
- **An adult must bring the medication to the school.**
- **A PHYSICIAN'S SIGNATURE IS NEEDED FOR BOTH PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS.**

PARENT / PRESCRIBER'S AUTHORIZATION

Name of Student: ______________________ Date of Birth: __________ Grade: ______

Condition for which medication is being administered: ______________________

Medication Name: ______________________ Dose: __________ Route: __________

Form of Medication: ______ Tablet/Capsule ______ Liquid ______ Inhaler Other __________

Time/frequency of administration ______________________

Relevant side effects: None expected ______ Yes/ Specify ______________________

Medication shall be administered from / / to / / .

Prescriber's name: ______________________

Telephone: ______________________ Fax: ______________________

Prescriber's address: ______________________

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Prescriber's Signature: ______________________ Date ______________________

PARENT/GUARDIAN AUTHORIZATION

I request designated school personnel to administer the medication as prescribed by the above prescriber. I certify that I have legal authority to consent to medical treatment for the student named above, including the administration of medication at school. I understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. **I authorize designated school personnel to communicate with the health care provider as allowed by HIPAA.**

Parent/Guardian Signature: ______________________ Date: __________

Home Phone #: ______________ Cell Phone #: ______________ Work Phone #: ______________

SELF -CARRY/SELF- ADMINISTRATION OF MEDICATION AUTHORIZATION/APPROVAL

Self- carry/self- administration of medication (including emergency medication) must be authorized by the prescriber.

Prescriber's authorization for self-carry/self-administration of medication: ______________________

Signature Date

Parent/Guardian's authorization for self-carry/self-administration of medication: ______________________

Signature Date